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ABSTRACT

The role of the special educator as a liaison between health department clinics and the school in treating the handicapped child is explored. Three reasons for the assignment of special educators to serve on staffs of state health department clinics are given: (1) the population of children which is referred to these clinics is far more likely than the general population of children to have educational problems; (2) these children often present an array of educational problems peculiar to the medical condition; and (3) these children present to the physician a complex set of organic and behavioral symptoms which may be exaggerated by conditions or expectations at school. The in-clinic and in-school roles of the educational consultant are considered separately; and the areas covered by educational assessment are listed. Five examples of intervention are given for cases from five different clinics: Adolescent Medicine Clinic (a 14-year-old boy with diagnoses of neurofibromatosis, arrested hydrocephalus, and median cleft face syndrome); Pediatric Neurosurgery Clinic (a 5-year-old girl with meningomyocele and neurogenic bladder); Child Neurology Clinic (a 5-year-old boy with neurological disorder characterized by clumsiness, language delays, and temper tantrums); Hematology Clinic (a 10-year-old boy with hemophilia); and the Cerebral Palsy Clinic (a 6-year-old girl with cerebral palsy). (SBH)

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THE ROLE OF THE EDUCATIONAL CONSULTANT SERVING AS THE LIAISON EDUCATOR BETWEEN HEALTH DEPARTMENT CLINICS AND LOCAL SCHOOL DIVISIONS

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THE ROLE OF THE EDUCATIONAL CONSULTANT SERVING AS THE LIAISON EDUCATOR BETWEEN HEALTH DEPARTMENT CLINICS AND LOCAL SCHOOL DIVISIONS

By

Inge W. Horowitz, O.T.R., M.Ed.

About ten years ago, a neurologist with a problem consulted a special educator for help. The physician could treat her young patients' neurological disorders, but she was concerned about the learning problems manifested by many of them. The collaboration which followed resulted, ultimately, in the state-level, interagency agreements in which all of us here participate.

There are basically three reasons for the assignment of special educators by the State Department of Education to serve on staffs of State Health Department clinics. First, the population of children which is referred to these clinics is far more likely, than the general population of children, to have educational problems. Secondly, these children often present an array of educational problems peculiar to their medical condition. The uniqueness of these educational problems sometimes requires the skills of a specialist, an educator who has specific training and experience in evaluating these children, and in recommending the necessary classroom and curricular adaptations. Finally, these children present to the physician a complex set of organic and behavioral symptoms which may be exaggerated by conditions or expectations at school. An understanding of what is happening to a child during his hours in school is sometimes an essential component of the comprehensive medical assessment.

The clinic educational consultant functions in two physical settings, first, in the clinic, and secondly, in the child's school, and then as liaison between these settings.

IN-CLINIC ROLE

When a child enters one of the clinic programs, he is evaluated by the various specialists on the team. The assessment of the educational consultant may include some or all of the following: Obtaining written parental permission to evaluate the child and to exchange relevant reports between the clinic and the school; Securing information from the school, either by phone, by written report, by onsight visit or through communication with the local public health nurse; and evaluating the child by means of formal standardized educational testing, informal testing and diagnostic teaching, and an interview with the child and the parent to obtain the school history and their perception of progress and problems. The information thus gained, relating to the child's educational experience, is recorded by the educational consultant and entered into the clinic record. The composite of clinic team findings and recommendations, relevant to the child's educational experience, is then communicated by the consultant in a written report to the school.

This report states evaluation results in terms of present capabilities and achievements; it identifies educational strengths and problem areas; and it includes specific recommendations to aid teachers and related service personnel in dealing with the child's problem. Reports are frequently used to help determine a child's eligibility for special services. The recommendations are also used by educators in writing IEP objectives.

After the initial total evaluation, the child returns to the clinic for periodic check-ups. The amount and frequency of follow-up varies with the type of clinic. In most cases, children must be routinely medically followed through adolescence. The educational consultant plays an active role in relation

to these return visits. Follow-up may include prior written or telephone communication with the school for feed-back on recommendations and for an up-to-date status report. During the child's return clinic visit, there is usually a conference with the child and parents to determine their perception of progress or persistent problems at school. Periodically, the consultant will repeat formal and informal testing to determine change. Follow-up information gained is noted in the child's medical record. The consultant's in-clinic role also includes attendance at meetings of the clinic staff when members report and discuss their findings. The school-related recommendations of these staffings are incorporated into the educational consultant's on-going communications with the school. Sometimes, there is a need for a group of school and clinic personnel to meet together on behalf of one or more of the children. The consultant makes the necessary contacts and arrangements for these conferences either in the clinic or in the school.

IN-SCHOOL ROLE

The educational consultant's second work place is in the school. This is where the child spends a large part of each day and where the consultant may be able to introduce certain techniques and adaptations to help minimize the child's frustration, and maximize his abilities. The school is also the place where there are trained observers of children who can provide the consultant with valuable insights to take back to the clinic team to aid them in their understanding of the total child. In addition to this liaison role with the public schools, educational consultants are sometimes needed to provide information about, and contact with private schools, tutors, summer camps, day care centers,

therapy programs and community recreational facilities. They are expected to maintain current files on such facilities and to be the clinic liaison as needed.

EDUCATIONAL EVALUATION

The clinic educational consultant must be able to perform a thorough educational assessment, mindful of the many factors which, in varying degree, may be at the root of a child's learning difficulties. These include:

Developmental delay

Intellectual deficit

Medical abnormality

Physical disability

Defects in central nervous system processing

Attentional problems related to hyperactivity or convulsive disorder

Emotional handicap

Social deprivation

Inappropriate school programming or

Parental mismanagement.

A number of recognized formal assessment tools are available to the educational consultant. The choice of tests used with a given child is determined by the child's age and by the availability and amount of recent psychological and educational testing. Any prior assessments are carefully studied. Then, in most cases, some broadside screening tests are administered to get to know the child and to search out patterns of learning style, strengths and weaknesses. For example, in screening infants and toddlers, the Denver

Developmental Screening Testor the EMI Assessment Scale may be used. Children of school age may first be given the Wide Range Achievement Test or the Peabody Individual Achievement Test.

The child's performance on these more generalized tests yields development or achievement level scores relative to other youngsters of his age. If prior data in the child's record is scanty, the evaluation is continued, using specific tests to more clearly define and quantify areas of learning ability and difficulty. The instruments available here include tests of discreet functions in visual-motor, gross-motor and fine-motor coordination; visual and auditory processing; verbal and written expression, and tests of the underlying skill components of reading and arithmetic. These formal tests are usually supplemented by informal diagnostic teaching and careful observation. An indepth educational evaluation, including breaks, requires approximately 3 to 4 hours.

EXAMPLES OF INTERVENTION

It should be noted that not all children referred to the educational consultant receive this type of evaluation. Sometimes other interventions are called for. In the time remaining, I shall describe some typical cases, their problems and solutions, as reported by several of Virginia's 30 clinic educational consultants.

(1) Adolescent Medicine Clinic

Steve was a fourteen year old boy with diagnoses of neurofibromatosis, arrested hydrocephalus, and median cleft face syndrome. Although his physiognomy suggested mental retardation, he was not mentally retarded. A complete metabolic work-up resulted in a diagnosis of Noonan's syndrome.

Severe learning disability problems were present, especially in the area of visual-motor performance. Following clinic evaluation, which included a complete educational assessment, suggestions were made to school personnel as to how to best work with this young man. After approximately one year of counseling by a fellow in Adolescent Medicine, Steve is presently being referred to the Department of Rehabilitative Services for evaluation and training. The educational consultant in the clinic will continue to follow-up on the progress of this patient.

(2) Pediatric Neurosurgery Clinic

Susie, age 5, has meningomyocele and neurogenic bladder. She is followed in 3 BCC clinics (also Orthopedics and Urology). She ambulates by means of a walker and is ver self-sufficient for her age. She recently had orthopedic surgery. Following a period of therapy she will hopefully be able to walk with short leg braces.

Susie is bright and highly verbal. Her parents were concerned when the school placement committee suggested a multi-handicapped class out of the neighborhood. They requested an educational assessment through the clinic. The clinic team recommended a regular school program.

The educational consultant plans to work with the teacher on physical adaptations in the classroom, and on strategies to alleviate the perceptual problems that were evident on the educational assessment. The consultant will monitor progress

and facilitate obtaining L.D. services for Susie if the need is apparent after she enters school in the Fall of 1979.

(3) Child Neurology Clinic

On admission to the clinic 5 years ago, Matt was 5 years old. He had a neurological disorder characterized by clumsiness, language delays, and temper tantrums. He was already a drop-out from 2 private Kindergartens.

The medical evaluation showed soft neurological signs. The psychological indicated high average potential, but significant visual-motor-perceptual impairment. The educational consultant's evaluation and subsequent report recommended placement in a very small group, a low-keyed atmosphere, manipulative materials, no emphasis on paper and pencil work, and adapted P.E. The parents placed Matt in a public school program where most of the recommendations were effected. Matt was followed in the clinic at 6 month intervals. When he was 7, the family moved to another school district. The educational consultant provided the receiving school with information and consultation resulting in a relatively smooth transition. At age 10, Matt is now in regular 4th grade where he has made a good social adjustment and excellent academic progress. He is currently being evaluated for the program for Talented and Gifted.

(4) Hematology Clinic

Tommy is a 10 year old boy with hemophilia, who had been on homebound instruction for the first three years of his school career. The clinic team recommended regular school attendance. The educational consultant intervened by means of conferences with teachers and pertinent school personnel during which information and educational materials on hemophilia were shared. Detailed arrangements made included doctors' orders written for emergency practice and coordination with the local rescue squad. These helped pave the way for comfortable acceptance of Tommy in school.

Over the past 3 years, Tommy has remained in school with only 2 brief periods of homebound instruction. There has been constant follow-up by the educational consultant and coordination between doctors recommendations, school evaluation, and placement for extra assistance in academic subjects. Tommy is learning and attending school regularly. He has improved in school, is getting along with his peers, and adjusting to his disease.

(5) Cerebral Palsy Clinic

Ann was a six year old girl with Cerebral Palsy, referred for in-hospital evaluation because of extreme regression in all areas. Although she had walked earlier, and for some time had a fairly uneventful pre-school situation, she had regressed to the point where she was no longer weight-bearing and no longer benefiting from instruction.

The interdisciplinary evaluation disclosed a highly unstable home situation. There were marital problems; Ann's only sibling had a terminal medical condition; the mother had attempted suicide and the father's reaction to this situation was to remove himself from it at every opportunity. Ann's physical condition was deteriorating, and she was reported to be hallucinating 85% of the time.

The clinic team felt that neither medical nor psychiatric intervention would help Ann without her removal from the home. The educational consultant was charged with seeking an appropriate residential school. This was a difficult assignment because most schools for the emotionally disturbed did not want an orthopedically handicapped child whose appliances might be used as weapons. Likewise, orthopedically oriented schools felt they could not cope with the behaviors of an emotionally disturbed child.

Several years have gone by. Ann is living out of state. A recent phone call to the school showed that she displayed none of the habits she had indulged in on her arrival at the hospital. She no longer hallucinates, she is walking, and she is achieving academically in school. The prognosis for Ann is considered to be excellent at this time.

Certainly, not all of the consultants' interventions have successful outcomes, but we feel good about having helped to improve the learning experiences of many, many handicapped children in Virginia.

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